NC DMA Pharmacy Request for Prior Approval - Standard Drug Request Form

Recipient Information **DMA-3488**

1. Recipient Last Name:_____ 2. First Name:_____
3. Recipient ID #_____ 4. Recipient Date of Birth:_____ 5. Recipient Gender:_____

Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid: ☐ Health Choice: ☐

Prescriber Information

7. Prescribing Provider #:_____ NPI: ☐ *or* Atypical: ☐
8. Prescriber DEA #: _____
Requester Contact Information
Name:_____ Phone #:_____ Ext:_____

Drug Information

9. Drug Name: **Viekira Pak (Initial Request)** 9b. Is this request for a Non-Preferred Drug? ☐ Yes ☒ No
10. Strength: _____ 11. Quantity Per 30 Days: **112**
12. Length of Therapy (in days): ☒ up to 30 ☐ 60 ☐ 90 ☐ 120 ☐ 180 ☐ 365 ☐ Other:_____

Clinical Information

Medical History:

1. ☐ Failed two preferred drug(s). If only one preferred drug is available, then failed one preferred drug.
List preferred drugs failed: _____
1a. ☐ Allergic Reaction 1b. ☐ Drug-to-drug interaction. Please describe reaction _____
_____

2. ☐ Previous episode of an unacceptable side effect or therapeutic failure. Please provide clinical information:
_____

3. ☐ Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to preferred drug(s).
Please provider clinical information: _____

4. ☐ Age specific indications. Please give patient age and explain: _____
_____

5. ☐ Unique clinical indication supported by FDA approval or peer reviewed literature. Please explain and provide a general reference: _____

6. ☐ Unacceptable clinical risk associated with therapeutic change. Please explain: _____
_____

Signature of Prescriber:_____ Date:_____

*Prescriber signature mandatory

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to CSC at: (855) 710-1969 Pharmacy PA Call Center: (866) 246-8505

North Carolina Department of Health and Human Services

Division of Medical Assistance
Viekira Pak Prior Authorization Form

Recipient Information

1. Recipient Name:_____ 2. Recipient ID #:_____

Drug Information

3. **Viekira Pak** 4. **112** Per 28 Days

5. Length of Therapy (Check ONE)[1]:

___ **First 8 weeks of 12** = Genotype 1a, without cirrhosis	VIEKIRA PAK + ribavirin
___ **First 8 weeks of 12** = Genotype 1a, with cirrhosis and treatment naïve	VIEKIRA PAK + ribavirin
___ **First 8 weeks of 24** = Genotype 1a, with cirrhosis and treatment experienced	VIEKIRA PAK + ribavirin
___ **First 8 weeks of 12** = Genotype 1b, without cirrhosis	VIEKIRA PAK
___ **First 8 weeks of 12** = Genotype 1b, with cirrhosis	VIEKIRA PAK + ribavirin
___ **First 8 weeks of 24** = Genotype 1x, liver transplant, F2 stage or lower	VIEKIRA PAK + ribavirin

Note: Follow the genotype 1a dosing recommendations in patients mixed genotype 1 infection.

[1]Approval will be for 8 weeks – a new PA is required with new HCV-RNA lab values to continue therapy

Clinical Information

1. The patient readiness to treat form is filled out and signed by the patient: YES or NO (circle one)*

2. The Child-Pugh Grade is: _____ (Can only be Grade "A" for Viekira)

3. The Genotype is: _____*

4. HCV-RNA (IU/ML) _____ and/or log10 value _____ (must be within last 6 months)*

5. Fibrosis stage _____ (see Hepatitis-C Clinical Criteria)*

6. Patient liver is decompensated? YES or NO (circle one)

***Readiness to treat form and actual lab test results MUST be attached to the PA to be approved.**

Fax all forms and lab work to CSC at: (855) 710-1969. The Standard Drug Request Form **MUST** be the first page faxed - Pharmacy PA Call Center: (866) 246-8505